John B. Semiannual Progress Report
January 31, 2004

The state has undertaken a number of significant activities within the past six months. These activities have been directed primarily toward strengthening the state's understanding of the problems to be addressed in EPSDT and beginning the work of developing solutions.

The Children's Cabinet and the Commissioners' EPSDT Task Force, under the direction of Tam Gordon, Special Assistant to the Governor for Projects, have brought new leadership and direction for the coordinated state effort to address *John B.* The following action steps have been taken:

1. A contract with Mathematica, Inc., was developed to provide an independent assessment of where we are. The principal Mathematica representative is Dr. Henry Ireys, who serves as the Court Monitor for the *Salazar* EPSDT Consent Decree in Washington, D.C., and who has broad experience in EPSDT programs, particularly programs for children with special needs. He was suggested by the plaintiffs' attorneys as an expert resource.

   Dr. Ireys' independent assessment was presented to the state in December 2003. His report included four main conclusions:

   a. The EPSDT program needs a full-time director and staff with sufficient time, authority, and experience to manage the EPSDT program across departments.

   b. Steps need to be taken to increase consumer awareness and provider support for EPSDT.

   c. There needs to be a long-term strategy for establishing a reliable EPSDT database.

   d. The state's approach to targeting children in state custody for special attention should continue and be extended to other vulnerable groups of children, such as youth with serious emotional disorders, children at risk for developing mental health problems, and children with chronic illness or disabilities.

2. The plaintiffs' attorneys were asked to provide the state with a list of what they perceived the key problems to be in implementing the *John B.* agreement. They provided a list of 105 problems. These problems were used as the basis for discussion at a two-day retreat in September which included the Commissioners, plaintiffs' attorneys, Special Master, Special Master's staff, Special Master's experts, and, for a time the Governor himself. The retreat was facilitated by Dr. Ireys. Problems were grouped into major areas, and workgroups are being identified to address each

Two other studies are in the preliminary stages of evaluating the effectiveness of the COEs. One is a follow-up study of the implementation of recommendations made by the COE. Monitoring follow-up is also an important primary function of the COEs, and the results of this study will be examined to determine how implementation of recommendations can be improved. As part of this process, COE staff is also asking DCS staff to rate the effectiveness of services.

During the spring of 2004 the COEs will begin a peer review process of cases. This study will also examine outcomes for children.

Implementation Team

The Implementation Team has continued its work of providing consultation in situations where children may enter custody if they do not receive a medically necessary service. The Implementation Team, which is housed in the Department of Health, has the authority to write Letters of Authorization (LOAs) when a necessary service cannot be obtained through regular means and, without the service, the child would likely enter custody. The Implementation Team (IT) received 105 case referrals between July 1, 2003, and January 1, 2004. The IT presently has 26 active cases.

In addition to many informal interdepartmental meetings, the Implementation Team routinely participates in regularly scheduled interagency meetings such as the joint COE/DCS/TennCare meetings, the Tennessee Chapter of American Academy of Pediatricians/TennCare meetings, and the EPSDT Task Force meeting. The IT has given presentations both to Community Service Agencies and to DCS CSA Health Care Advocacy Staff on process of accessing behavioral health services for at risk TennCare children. The IT has given similar presentations at the Family Voices Statewide Policymaker Conference and also to the Family Voices Statewide Staff by teleconference. The IT gave a joint presentation with the Center of Excellence to the Select Committee on Children and Youth concerning our role and function in providing medically necessary mental health services for at risk children and participated in a panel discussion about service acquisition for at risk TennCare children at the Joint Conference on Juvenile Justice.

With exceptions as noted below, the IT was able to assist in securing services for children by working with entities such as the behavioral health organization (BHO), providers, the court system, the Department of Children's Services, the Division of Mental Retardation Services, and the Department of Education.

Five children were in custody at time of referral and ten children came into custody after referral. Two children came into custody due to felony charges and not due to lack of services. Four children came into custody because of non-custodial placement issues, (i.e. lack of appropriate non-custodial guardian/caregiver). In two cases, services were arranged through IT liaison efforts with BHO but court would not accept non-custodial arrangements. In one case, the child was not TennCare eligible. In two cases, there was a 24-

hour or less timeline between referral to the IT and the court hearing so that there was essentially no time for the IT to collect information and assist in development of a treatment plan. In one of these cases, the provider had not even made a request for services to the BHO and the court was not willing to allow any further time. The IT was subsequently able to get three children released from custody and appropriately placed through a letter of authorization (LOA).

Summary of the letters of authorization between July 1, 2003 and December 31, 2003.

- The bulk of the LOAs were written for children living in either Middle or West Tennessee. Only 11 LOAs were written for children living in East Tennessee.
- The age ranges of children receiving LOAs were from age 6 to age 20. The average age was 14.5 years.
- 2 LOAs were for alcohol and drug rehab programs
- 13 were for psychiatric based residential treatment programs
- 2 were for sex offender specific residential treatment
- 4 were for level IV sub-acute residential treatment
- 3 were for in home comprehensive child and family treatment (CCFT)
- 1 was for wilderness program
- 13 letters were for children with dually diagnosed mental retardation and mental health issues (MR/MH) for specialized care through either Youth Villages CHOICES program or King's Daughters.

20 letter of authorizations were continuation LOAs, meaning they were extensions of LOAs that had been written previously. Of these, 17 were for MR/MH children

Mental Health: Youth Villages Specialized Crisis Services for Children and Adolescents

Update on Crisis Services:

The Department of Mental Health and Developmental Disabilities (TDMHDD) continues to work in collaboration with the BHOs to monitor Youth Villages through several methods. One method is by using the Youth Villiages' Monthly Volume Reports. These reports include the following data for each region: number of calls received, number of face to face encounters, average time spent in face to face encounters, location of the encounter, average response time, and patient disposition. Additionally, Youth Villages collects a second level of data using the referral source survey. This opinion survey about Youth Villages' performance is collected on a monthly basis from mental health workers, medical personnel, community members, law enforcement/juvenile personnel, school personnel, DCS staff, and others. Although the BHO remains the lead on monitoring these reports, the TDMHDD Office of Management Care also reviews the reports and discusses any concerns that they have with both BHOs and Youth Villages.

area. The Outreach Workgroup has had several meetings and identified a number of new outreach strategies, which are discussed later in this report.

A new contract with Mathematica has been developed to obtain their assistance in structuring the activities of the workgroups and developing a management tool which will allow the state to track progress effectively and accurately.

A programmatic change was made at TennCare during this period, which has had a dramatic impact on the number of appeals filed for children. Effective July 1, 2003, all pharmacy services are being delivered by a Pharmacy Benefits Manager. This action alone has reduced the overall numbers of EPSDT appeals from an average of over 2,000 per month to 1,000 per month.

Two key personnel appointments were made during this period. Dr. Viola Miller was appointed Commissioner of the Department of Human Services on December 23, 2003. She is a veteran child welfare administrator and the former Secretary of Families and Children for the Commonwealth of Kentucky.

TDMHDD hired a new Director of Children and Adolescent Services during this period. She is Dr. Freida Hopkins Outlaw, who came to Tennessee from the University of Pennsylvania, where she was Associate Professor of Psychiatric Mental Health Nursing.

Sections of this report and the pages on which they begin are as follows:

During this period all MCOs submitted proof of documentation to TennCare of the updated list of specialists along with proof of timely mailing.

REVIEW OF MCO TRANSPORTATION PROVIDER AGREEMENTS

During this period, OCDC reviewed and approved the transportation agreement for Blue Cross Blue Shield of Tennessee.

MONITORING FOR PROVIDER NETWORKS DEFICIENCIES

The Provider Networks section of TennCare issued forty-nine (49) provider network deficiency notices to seven (7) MCOs. OCDC tracked and monitored receipt of forty-nine (49) Corrective Action Plans (CAPs) for provider network deficiencies noted in various counties and specialties. All CAPs were received timely.

EPSDT DIRECTIVE ANALYSIS

An analysis of all directives issued by the TennCare Solutions Unit **(SEE ATTACHMENT A.)** for this reporting period is provided in a series of graphs.

LIQUIDATED DAMAGES ASSESSED

Per Paragraph 101. of the Revised John B. Consent Decree, TennCare will review appeals filed under the TennCare Program to determine whether deficiencies or repeated violations necessitate financial penalties upon managed care contractors and other state agencies which have inappropriately denied EPSDT services to children.

Part I: Outreach and Screening
Paragraphs 39-52

A. Outreach

EPSDT outreach occurs through the MCOs, through other states agencies such as DCS and the health department, and through contracts with outside agencies such as the Tennessee Homeless Coalition.

MCO marketing materials

MCO marketing materials must receive prior approval in order to ensure compliance with marketing guidelines. During the past six months the following submissions were reviewed by TennCare

MCO Name	Document Name	Date Received	Date Approved	Revisions
Better Health	Member Winter Newsletter	8/28/2003	10/15/2003	Yes
Better Health	EPSDT Script	9/03/2003	10/15/2003	Yes
Better Health	Revised Winter Newsletter	10/30/2003	10/30/2003	No
BlueCare	Revised Transfer New Members Letter (Xantus)	7/07/2003	7/14/2003	No
BlueCare	Primary Language Request on EPSDT Postcard	7/08/2003	7/24/2003	No
BlueCare	Spanish Member Newsletter 2003 3rd Quarter	7/15/2003	8/21/2003	Yes
BlueCare	Member 2003 Handbook (English)	8/21/2003	9/19/2003	Yes
BlueCare	EPSDT Display Keep Your Child Healthy and Happy	9/08/2003	9/29/2003	Yes
BlueCare	Member 4 th Quarter 2003 Newsletter	9/30/2003	10/30/2003	Yes
BlueCare	EPSDT Inactive & Delinquent Member 3rd Quarter Letter	11/21/2003	12/02/2003	No

MCO Name	Document Name	Date Received	Date Approved	Revisions
BlueCare	New Member Letter with Lead Poisoning Brochure	10/22/2003	10/30/2003	No
BlueCare	Spanish Version 4th Quarter Newsletter	11/06/2003	11/25/2003	Yes
Doral Dental	Member Newsletters 3rd and 4th Quarter	09/28/2003	9/29/2003	No
John Deere	Member Newsletter Summer/Fall 2003	8/14/2003	9/09/2003	Yes
John Deere	Health Talk Newsletter – Preventive Care	11/07/2003	11/26/2003	Yes
OmniCare	Member Handbook 2003	7/18/2003	08/21/2003	Yes
OmniCare	3rd Quarter Member Newsletter EPSDT Reminder	8/07/2003	8/27/2003	Yes
OmniCare	Special Programs Brochure	9/15/2003	10/31/2003	Yes
OmniCare	OCHP 4th Quarter Member Newsletter	10/24/2003	10/31/2003	No
TennCare Select	Revised Transfer New Members Letter (Xantus)	7/07/2003	7/14/2003	No
TennCare Select	EPSDT Postcard Primary	7/08/2003	7/24/2003	No
TennCare Select	Spanish Member Newsletter 3rd Quarter 2003	7/15/2003	8/21/2003	Yes
TennCare Select	Member 2003 Handbook (English)	8/21/2003	9/19/2003	Yes
TennCare Select	EPSDT Display Keep Your Child Healthy & Happy	9/08/2003	9/29/2003	Yes
TennCare Select	Spanish Version 4th Quarter Newsletter	11/06/2003	11/25/2003	Yes
TennCare Select	EPSDT Inactive, Contact & Delinquent Member Letters 3rd Quarter	11/21/2003	12/02/2003	No

MCO Name	Document Name	Date Received	Date Approved	Revisions
TennCare Select	Member 4th Quarter 2003 Newsletter	9/30/2003	10/30/2003	Yes
TennCare Select	New Members Letter w/Lead Poisoning Brochure	10/22/2003	10/30/2003	No
TLC	Healthy Rewards Members Fall 2003 Newsletter	10/28/2003	11/03/2003	No
TLC	Winter 2003 Member Newsletter	10/09/2003	10/31/2003	Yes
TLC	Spanish Version Winter 2003 Newsletter	11/07/2003	12/05/2003	Yes
TLC	Fall Member 2003 Newsletter-English	7/29/2003	8/21/2003	Yes
TLC	Fall Member 2003 Newsletter-Spanish	8/22/2003	9/29/2003	Yes
VHP	Member Newsletter Summer 2003	8/08/2003	8/27/2003	Yes
VHP	Caring for Your New Baby, Yourself & Your Family	10/29/2003	11/06/2003	No

DCS EPSDT outreach activities

DCS Health Advocacy continued its work to ensure that EPSDT outreach is seamlessly part of the DCS permanency planning process. Working with DCS Permanency Support Units and DCS Foster Care, DCS Health Advocacy developed a new EPSDT section of the Permanency plan template which guides the DCS home county case manager to discuss the child's EPSDT with the child and family team. The "Train the Trainer materials" are currently under development to ensure that DCS case managers discuss EPSDT screenings during permanency planning meetings. Training on this template will be taking place over the next six months.

Since the development of the EPSDT aging out of custody pamphlet, an average of 50 pamphlets advising youth how to keep their TennCare and informing them of the EPSDT rights have been sent out each month.

In order to reach foster parents and help them understand both the purpose of the screenings and the EPSDT rights that TennCare children have, DCS health unit staff conducted EPSDT outreach at Foster Parent Meetings. The meetings were held on:

The chart below reflects 30,248 screenings done July 1, 2003, through December 31, 2003.

TDH EPSDT Screens--Current Fiscal Year to Date

Region	YR 2003 July Tot Units	MON August Tot Units	September Tot Units	October Tot Units	November Tot Units	December Tot Units	Grand Total Tot Units
1 - Northeast	392	589	494	486	333	412	2,706
2 - East TN	364	382	319	349	277	241	1,932
3 - Southeast	289	327	253	229	116	127	1,341
4 - Upper Cumberland	515	479	387	329	288	307	2,305
5 - Mid Cumberland	762	769	605	534	362	402	3,434
6 - South Central	545	483	346	374	293	231	2,272
8 - West TN	1,349	1,258	975	1,113	974	1,189	6,858
9 - Shelby	1,109	1,411	779	797	613	488	5,197
D - Davidson	65	58	58	64	61	16	322
H - Hamilton	191	217	143	150	137	94	932
J - Madison	115	127	83	105	83	44	557
K - Knox	353	366	291	326	232	229	1,797
S - Sullivan	129	124	133	97	53	59	595
Grand Total	6,178	6,590	4,866	4,953	3,822	3,839	30,248

Screenings sometimes lead to referrals for other services. Examples of positive outcomes from referrals are:

A two-month-old child in for WIC and immunizations. The infant had not been seen since discharge from the hospital. The mother stated that the infant had tested positive for Down's syndrome and was interested in some information on it. The nurse noted that the infant had labored respirations and also poor weight gain. She called the PCP who asked her to make a referral to LeBonheur Hospital. When assessed at LeBonheur, the physician made an immediate referral to a cardiologist where the infant was found to have an atrioventricular defect. Heart surgery was performed and the infant is doing well.

A newborn infant in for WIC was found by the nurse to be in actual respiratory distress. An immediate referral was made to the PCP where the infant was sent to the hospital by ambulance. The infant was diagnosed with the RSV virus and hospitalized. One month later, the mother reports the baby is doing well.

at TennCare to plan quarterly statewide video conferences and a statewide Policymakers' Seminar.

A video conference conducted on October 3, 2003 addressed updates of the TennCare program, System of Care, Cultural Competency, and Safety Net. The next scheduled video conference will be conducted on February 6, 2004.

The Children's Policymakers Work Group is currently planning the Fourth Annual Policymakers' Discussion on Children's Health scheduled for April 23, 2004 at the Westminster Presbyterian Church in Nashville.

TennCare shelter enrollment project

The purpose of the Shelter Project is to facilitate enrollment of uninsured homeless children in TennCare. Staff coordinates and conducts regional training sessions for shelter staff about their roles in enrolling children in TennCare. They develop effective outreach activities to enroll eligible uninsured children and maintain their enrollment. Staff collaborates with TennCare and the Department of Health to develop and distribute EPSDT information materials targeted to eligible homeless families to inform them about the availability of services and specifically EPSDT screening and treatment services. They coordinate and conduct regional EPSDT "train the trainer" sessions for shelter staff and homeless service providers. A Shelter Help Line telephone number that families can use to obtain information about EPSDT services, how to get the services, and how to get the appointments scheduled and get transportation to the services is provided.

An infant with a misshapened head was referred to the PCP and later had surgery for craniostenosis.

EPSDT Dental Activities

Child enrollees are referred to a dentist for an oral evaluation beginning at age (3) three and yearly thereafter, in accordance with the periodicity schedule. However, if deemed medically necessary, a dental referral may be made at any age. Covered dental services under TennCare rules and guidelines include preventive, diagnostic and treatment services to enrollees under age (21) twenty-one. Procedures defined by Current Dental Terminology (CDT-4) codes are covered for children as medically necessary.

Based on the parameters established by TennCare, as well as enrollee-to-dentist ratios, analysis indicates that child enrollees have good access to dental care. Although there is no "universally accepted" population-to-dentist ratio, TennCare has compared our ratio to the number used under Terms and Conditions for Access in the Waiver, where the patient load is given as 2,500 or less for physicians and dentists. In October 2003, TennCare had a ratio of 755 child enrollees ages 3 through 20 to each participating dental provider. The population-to-dentist ratio in the general child population in Tennessee for ages 5-24 is estimated to be 577:1.

TennCare has also historically utilized the GeoNetworks "capacity" report to analyze waiver compliance. GeoAccess analysis revealed no deficiencies in the network at ratios of 2,500:1, at half of that ratio 1,250:1, or even at 950:1. Based on a GeoAccess parameter of 2,500 members to one dentist, the average distance from a TennCare enrollee to a participating dental provider was 3.9 miles. At a ratio of 1,250:1 the average distance was 4.4 miles.

From October 1, 2002 through November 25, 2003, the dental provider network has grown by approximately 74% from 386 unduplicated dental providers to 673 unduplicated providers. Surveys reveal that approximately 90% of participating dentists are actively accepting new TennCare patients into their practices indicating that the existing capacity to treat TennCare children has not yet been exceeded.

At the most recent TennCare Dental Advisory Committee Meeting on January 9, 2004, representatives of the Tennessee Dental Association and the Pan Tennessee Dental Association indicated that they were not aware of any dental access issues related to TennCare enrollees.

Since July 1, 2001, a partnership between the Bureau of TennCare and the Tennessee Department of Health has resulted in the provision of statewide oral disease prevention services for children in public elementary schools at high risk for dental caries. Services include dental screening, referral, follow-up, sealant application, oral health education, oral evaluation and dental outreach.

October 21, 2003-Cookeville at Tennessee Tech
October 29, 2003-Knoxville at UT Conference Center
November 17, 2003-Nashville at Wyndham Hotel

The outreach was described in the program as providing "information on children's right to receive medical services, including present information on TennCare, EPSDT screenings and ways those screenings may help to detect health or mental health problems."

DCS Health Advocacy also presented EPSDT information as part of the General Session Judges conference held on September 23, 2003. The focus of this event was the changes to DCS permanency plan which now will include EPSDT information and information concerning the right to treatment.

Department of Health EPSDT outreach and advocacy

The Department of Health, through the 95 rural and metro health departments, continues to act as advocate for the TennCare population. Some of the ongoing activities are:
Informing and educating families about the importance of the EPSDT screening when they present for other services such as WIC, immunizations, family planning
Ascertaining the current EPSDT status according to the periodicity schedule
Providing a screening if the parent wishes and time allows
Scheduling future appointments with the child's PCP or the local health department according to the wishes of the parent
Assisting with appeals when services are denied, especially for children with special health care needs (92% of the children in the CSS program are on TennCare)

Some examples of outreach activities include:

The Jackson County Health Department in the Upper Cumberland Region conducted a Neighborhood Children's Health Festival at the Housing Authority office. The event was promoted by local health department staff going door-to-door with colorful flyers inviting families to have eligible children screened. Eight community agencies participated in the Health Fair.
The Wilson County TennCare for Kids Coalition sponsored a Back-to-School Fair which was held at the local health department. It was promoted by a Channel 2 News spokesperson who spoke of the importance of EPSDT screenings and having eligible children enrolled in TennCare. The mascot, Ozzy the Cougar from the Nashville Sounds, entertained the children.
In Scott County, home visitors are making visits to families to educate them on the importance of the EPSDT screenings.

Children's Policymakers Work Group (CPWG)

The Children's Policymakers Work Group (a merger of the TennCare and Children Work Group and the Policymakers Planning Group) met twice a week

B. Screening

The state has continued to promote full and timely screenings through regular provider education and through collaboration with the Tennessee Chapter of the American Academy of Pediatrics and other groups. The health department is an active provider of screening services; their staff provides screenings to all DCS custody children. Dental screenings are performed by both the health department and TennCare through its Dental Benefits Manager, Doral Dental.

Health department screening services

The Department of Health, through the 95 county health departments, has provided EPSDT screenings since July 2001.

The screening activities were expanded in June 2003 with the new responsibility for screening all children in the custody of the Department of Children's Services.

Thanks to the total commitment of local health staff, this effort is now functioning well after only seven months. In fact, the screening numbers for the past six months reflect an increase of 4200 over the same time period for 2002.

Every effort is being made to assist DCS to meet such guidelines as ensuring that 1) initial screenings are provided within 30 days of entering custody and 2) that the seven components of the screening are done, documented and written information is provided to the DCS case manager and to the primary care physician via letter.

In a recent review of 504 Department of Health medical records, the TennCare Oversight staff found that 90.5% of them had the seven components documented. It will continue to be a goal of this department to increase this percentage of compliance with the provision of the seven component screening.

Currently, School-based dental prevention services are being delivered in all 13 public health regions. The following figures represent statewide data for some of the services delivered through the Department of Health's School-based Dental Prevention Project for the first half of this fiscal year from July 1, 2003 through December 31, 2003. To date in this fiscal year, 51,679 children received a dental screening. Of these screenings, a total of 16,204 children with unmet dental needs were referred for dental care. This is a referral rate of 31%. A total of 12,455 TennCare children had 66,901 dental sealants applied to their teeth for an average of 5.4 teeth sealed per child. Additionally, 17,467 TennCare children received a comprehensive oral evaluation by a licensed dentist. During this reporting period, 56,968 children received oral health education programs at their schools by a public health dental hygienist. As a result of this program 48,303 children benefited from TennCare outreach. One hundred percent of the children identified as having a priority unmet dental need received follow-up.

Tennessee Chapter of the American Academy of Pediatrics (TNAAP) Activities

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) contract to provide assistance to TennCare on EPSDT was extended for another year. In addition to working with TennCare to identify barriers and improve compliance, the current contract was expanded to include a coding educator. Current areas that TNAAP is working with TennCare include the following:

- **Provide assistance to improve EPSDT screening rates**
  - Conducted 28 introductory office visits (65 physicians).
  - Conducted 15 expanded office visits/trainings (100 physicians).
  - Attended 5 TMA workshops and promoted EPSDT and appropriate coding (300 participants).
- **Education of providers to improve completeness and documentation of screens**
  - Refined EPSDT and Coding Manuals. Posted them on the website.
  - Revised TNAAP brochure promoting EPSDT services.
  - Distributed educational packets to physician's offices, at TMA workshops and at trade shows.
  - Promoted EPSDT screening and coding at the Annual Family Physicians Meeting. (300+ physicians).
  - EPSDT Booth at TNAAP CME Meeting and Annual Awards Luncheon promoting screening and appropriate coding.
  - Conducted 2 EPSDT and Coding Trainings (basic and advanced) at the LeBonheur Hospital Auditorium in Memphis (more than 300 attendees including 220 pediatricians and 65 family practitioners).
  - Published EPSDT related topics in the 2003 Summer TNAAP Newsletter.
    - The role of the "Implementation Team".
    - The DCS children in custody screening program at the health department.

        - Announcement of "medical passports" being available for EPSDT screens.
        - Information on how to obtain results of newborn metabolic screens.
    - Wrote article for Tennessee Medicine (TMA, August 2003) regarding EPSDT forms.
- **Met Regularly with TennCare**
    - TNAAP – TennCare EPSDT meeting was held monthly.
        - Identified barriers and exchanged information on how to improve screening rates.
    - Attended TennCare MCO Medical Director's meetings to share their activities.
    - Attended various other meetings including Children's Work Group, the Centers of Excellence and Commissioner Robinson.
    - TNAAP EPSDT Director served as liaison with Department of Health on EPSDT related issues.
    - Provided consultation to the Office of Medical Director on a regular basis.
- **Participated in the Screening Guidelines Committee**
  The Screening Guidelines Committee was reconvened during the 4th quarter of 2003 to undertake a comprehensive review of the guidelines and make recommendations for revision of the periodicity schedule to ensure it is consistent with nationally recommended guidelines. The Committee made recommendations to enhance the vision, hearing and dental screening guidelines. They begin work on the developmental assessment tools. The work on the developmental assessment tool and training surrounding this tool will be completed during the 1st quarter of 2004. The Committee plans to recommend a comprehensive education program supported by a TNAAP educator prior to full implementation. Additionally, a pilot program to fully test the tools will be undertaken in selected offices.

Quality Oversight
TennCare Medical Record Review

The medical record review report which follows is for federal fiscal year 2002 and covers the period of October 2001 through September 2002. The report shows that the documentation completion rate for EPSDT services continues to increase from one year to the next.

EPSDT medical record reviews will be performed this year for federal fiscal year 2003. The tool that will be used for the medical record review was revised by Dr. Hollis, TennCare Medical Director. A meeting of all the MCOs' EPSDT coordinators took place on January 12, 2004. During this meeting TNAAP educated about the process of medical record reviews, and performed some mock audits for the attendees.

From October 2002 to May 2003, on-site medical record reviews were conducted statewide. In all, 4405 medical records were audited in 904 provider offices. The sites included 826 medical providers' offices and 78 Department of Health clinics. The purpose of the review was to determine the extent to which medical providers and managed care companies complied with the delivery of comprehensive Early and Periodic Screening, Diagnostic and Treatment services to children enrolled in the TennCare program, by assessing the completeness of the medical record documentation of a sample of records.

MEDICAL RECORD REVIEW TOOL

The audit tool and guidelines utilized for the review were based on the American Academy of Pediatrics Recommended Screening Guidelines, Center for Medicaid/Medicare Services (CMS) requirements, and the state EPSDT Guidelines Committee report. The tool identified each enrollee by name, social security number, provider, date of birth, date of service, and MCO affiliation.

METHODOLOGY

A random sample of children who received EPSDT services during the period October 2001 and September 2002 was selected for audit. Data considered were paid original records and were pulled from office visits, and laboratory or community health centers (claim type 6 or 10) with procedure codes 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99431, 99432, Y0100, Y0102, Y0103 or any diagnosis code V20-V20.2, V70.0, V70.3-V70.9. The records were pulled for children who were under 21 years of age on the date of service for the well child visits.

INTER-RATER RELIABILITY TESTING

Reliability testing was completed on 2.84% (125) of the medical records. The average percent agreement was 92.96%, for the 125 records.

FINDINGS

A total of 4405 records of enrollees under the age of 21 were audited. Various statistics were calculated at the end of the medical record audits:

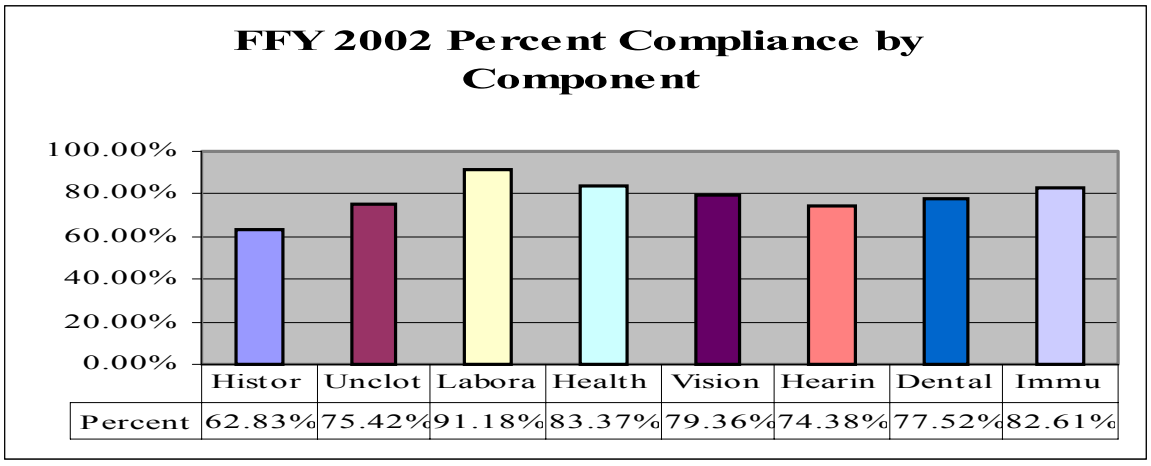
TABLES AND GRAPHS

Table 1: Age Distribution of Children FFY 2000 to FFY 2002

	< 1	1to 2	3to 4	5,6,7	8,9,10,11	12,13,14, 15, 16	17,18,19, 20	**TOTAL**
Records for FFY 2000	217	70	37	45	35	26	16	446
Records for FFY 2001	201	150	98	101	83	78	34	745
Records for FFY 2002	969	783	601	585	501	682	284	4405

Table 2: Number of Records Audited for each MCO FFY 2000 to FFY 2002

	BC	**BHP**	**JD**	**OMNI**	**PHP**	**TCS**	**TLC**	**UNIV**	**VHP**	**XHT**	**Total**
FFY2000 Records	188	0	30	30	30	0	30	0	30	33	371
FFY2001 Records	99	29	91	96	71	82	42	51	88	96	745
FFY2002 Records	534	400	476	335	457	410	495	420	410	468	4405



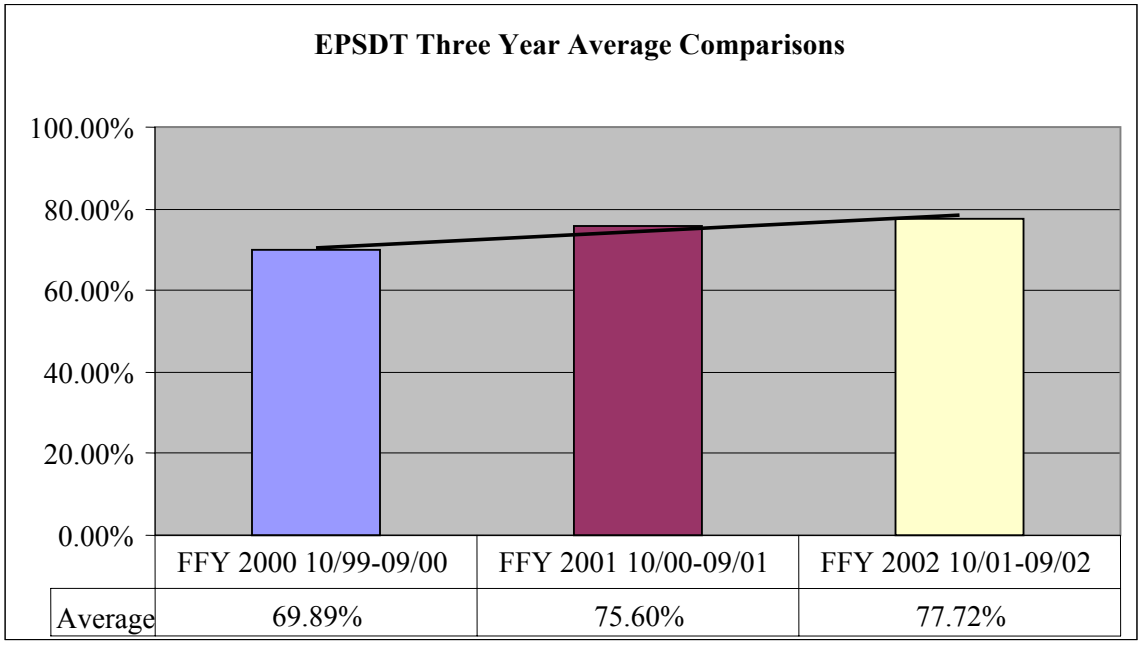
OUTCOMES

The overall documentation compliance rate statewide for well child check-ups in the TennCare EPSDT-eligible population in FFY 2002 was **77.72%**. This rate is higher than **75.60%** that was recorded for FFY 2001. The documentation

compliance rate has improved by **7.8%** since 2000, when the rate was **69.89%**. Documentation compliance for each region was also calculated. A trend analysis was performed for each MCO, for each grand region, and for TennCare overall.

The upward trend identified in the documentation completion rate since 2000 was subjected to a univariate linear regression on a time variable. The analysis showed that the improvement over time was statistically significant. The goodness of fit of the model used is acceptable with an adjusted R-squared of 0.9867. The standardized coefficient of time which describes the slope of the trend is 0.99555, with a p-value of p=0.0044.

Figure 4: TennCare Three-year Trend Report: FFY 2000 To FFY 2002



REPORTED 2001 REPORTED 2002 REPORTED 2003

REFERRALS

During the medical record review, records reflected that referrals to specialist were being made. Of the 4405 records reviewed, 441 referrals were made for the dates of service audited. The referral percentage for

various services increased between 2001 and 2003 as seen from the following calculation

Year	# Referrals	# Records Audited	% Referrals
2001	25	446	5.6
2002	70	745	9.3
2003	441	4405	10.0

APSP results are presented below

	CMS 416 Screening Percentage *	Results of Medical Record Review **	Adjusted Periodic Screening Percentage (APSP) *** **Target: 80% by FFY 01**	Dental Screening Percentage (DSP) **** **Target: 80% by FFY 03**
FFY 96 (Baseline)	39%	56.2%	21.9%	28.2%
FFY 99 (first full year after Consent Decree was finalized)	36%	55.1%	19.8%	28.5%
FFY 00	45%	69.9%	31.5%	33%
FFY 01	50%	76%	38%	38.3%
FFY 02	54%	77.12%	42.%%	36%

RECOMMENDATIONS

Based on the findings from this audit, TennCare is evaluating the EPSDT program and will make additional adjustments to improve the results.

Although the patterns observed since 2000 show positive trends in the medical record documentation process by physicians and other providers, there are still variations among the grand regions. Managed Care Companies in the West region are encouraged to expand their provider education programs

Department of Health

The Department of Health, through the 95 county health departments, has provided EPSDT screenings since July 2001.

The screening activities were expanded in June 2003 with the new responsibility for screening all children in the custody of the Department of Children's Services.

Thanks to the total commitment of local health staff, this effort is now functioning well after only seven months. In fact, the screening numbers for the past six months reflect an increase of 4200 over the same time period for 2002.

Every effort is being made to assist DCS to meet such guidelines as ensuring that 1) initial screenings are provided within 30 days of entering custody and 2) that the seven components of the screening are done, documented and written information is provided to the DCS case manager and to the primary care physician via letter.

In a recent review of 504 Department of Health medical records, the TennCare Oversight staff found that 90.5% of them had the seven components documented. It will continue to be a goal of the Health Department to increase this percentage of compliance with the provision of the seven component screening.

Successful Outcomes

Children are routinely being referred to primary care physicians for such findings as:

- Speech/language delays
- Hearing problems
- Poor weight gain
- Behavioral/developmental problems
- Signs of abuse/neglect

And for more serious findings, such as:

- Heart murmurs
- Respiratory difficulties
- Hydroceles
- Hip dislocation
- Cleft palate

Examples of positive outcomes from referrals are:

- A two-month-old child in for WIC and immunizations. The infant had not been seen since discharge from the hospital. The mother stated that the infant had tested positive for Down's syndrome and was interested in some information on it. The nurse noted that the infant had labored respirations and also poor weight gain. She called the PCP who asked her to make a referral to LeBonheur Hospital. When assessed at LeBonheur, the physician made an immediate referral to a cardiologist

where the infant was found to have an atrioventricular defect. Heart surgery was performed and the infant is doing well.

- A newborn infant in for WIC was found by the nurse to be in actual respiratory distress. An immediate referral was made to the PCP where the infant was sent to the hospital by ambulance. The infant was diagnosed with the RSV virus and hospitalized. One month later, the mother reports the baby is doing well.
- An infant with a misshapened head was referred to the PCP and later had surgery for craniostenosis.

Part II: Diagnosis and Treatment Paragraphs 53-77

Centers of Excellence

The three Centers of Excellence for Children (COEs) are located at East Tennessee State University (ETSU), the University of Tennessee at Memphis (UT-M) and Vanderbilt University (VU). The Centers of Excellence for Children Were created to augment existing capacity to provide direct and ancillary medical and behavioral health services to children in, and at risk of state custody. The COEs support DCS in integrating placement, family, health and developmental needs into a comprehensive and coordinated care plan based on the child and family's unique needs. The COEs provide direct services as well as comprehensive record reviews, consultation, training, and follow-up.

Size of staff and caseloads varies by COE. This is determined by the percentage of children in state custody who originate from the region served by a particular COE. Since their inception the COE have served a total of 1,325 children. During the past six months, the COEs have triaged 341 referrals and seen 231 children for direct services or to develop careplans. The COEs also continue to be engaged in training activities and during the past six months presented 41 contact hours of training to 871 individuals.

During the past six months several projects were initiated to evaluate the effectiveness of COEs and to provide opportunities for continuous improvement of their services. DCS staff provided oversight of a process whereby cases with adverse out comes, who were seen by the COEs, were nominated for review by DCS case workers, the Implementation Team and pediatricians associated with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP).

Very few cases were found that could be subjected to a further root cause analysis, and in these cases the negative outcomes were attributed to other factors than failure in the services provided by the COE. This process will be repeated on a yearly basis as another on way to ensure that there is identification of cases where there may have been a failure in COE services.

TDMHDD also has regular meetings with the BHOs and Youth Villages to review reports of problems. This includes continuing to monitor any external complaints that are presented to the BHOs or TDMHDD. The BHOs continue to conduct a thorough investigation of each complaint and work toward resolution of all complaints in a timely manner. TDMHDD monitors the BHOs' investigation of external complaints by conducting random investigations of some of these same complaints. This plan will better oversee and assure that Youth Villages is delivering timely and high quality services.

Part III: Coordination
Paragraphs 78-83

The Children's Cabinet and the Governor's EPSDT Coordinating Committee continue to explore ways state departments can better serve the health care needs of the under-21 TennCare population. The TennCare director, a Governor's office cabinet-level representative, the deputy commissioner in charge of Mental Retardation and the commissioners of the state departments of Health, Human Services, Children's Services, Education and Mental Health are exploring ways to employ previously untapped resources to assist in communicating with and providing services to this population.

The commissioners of the above-mentioned departments have appointed representatives to work groups which, when fully up and running, will meet on the average of three times each month, including one meeting with the EPSDT Coordinating Committee (which serves as the group's steering committee). The first work group – outreach – which began on Dec. 19, 2003, has already made progress. This work group has identified initiatives, reported to the steering committee, and gotten permission to proceed with plans:

To mention a couple:

The Department of Education is moving toward including information about EPSDT in first-day-of-school (beginning August 2004) packets that go home with all students. DOE will require parent/guardian signature upon receipt.

The Department of Health and TennCare are launching a state-wide community outreach effort that includes a call center and an aggressive information campaign.

Also, the Steering Committee has taken a fresh look at TennCare' s contract with the Tennessee Chapter of the American Academy of Pediatrics and will better utilize the resources TNAAP offers, especially in the area of provider education.

With respect to the specific agencies mentioned above, TennCare has a Title V agreement with the state health agency, the Department of Health, which addresses MCH and CSS services, as well as services offered by some other agencies such as DCS. (Children's Special Services is the name for the agency that used to be called Crippled Children's Services.) The Department of Health also manages the WIC program and makes these services available to eligible TennCare enrollees. TennCare eligibility determinations are done at the Department of Human Services, which enrolls applicants in social service programs for which they may be eligible. There is a formal IDEA agreement among all the child-serving departments that is administered by the Department of Education.

TennCare has initiated two new projects with the schools in recent months. One, the Medicaid Administrative Claiming project, will allow school systems to be reimbursed for EPSDT outreach services they provide. The second will allow payment for TennCare services delivered to IDEA students. Both projects are awaiting approval from CMS.

Part IV: Coordination and Delivery of Services to Children in State Custody Paragraphs 84-93

DCS has the responsibility for the care and protection of children in state custody. The challenge of delivering DCS provided services as well as coordinating the delivery of other needed services has been recognized in the John B. consent decree and the performance of these tasks is one in which DCS is committed to improving.

DCS efforts to ensure that all children in custody have received a complete EPSDT screening continue. According to the DCS Monthly EPSDT Appointment report the following percentages of youth have been taken for their EPSDT screening[1].

- July – 97.22%
- August – 95.46%
- September – 95.69%
- October – 97.63%[2]

DCS is continuing in its efforts to understand why certain children have not received their EPSDT screenings. Each month, DCS central office health advocacy is requesting that the regional office complete an EPSDT undocumented report. One spreadsheet from each quarter is then compiled to inform management of problem areas. For the last quarter, the August data

[1] These are the percentages of youth in custody in the John B plaintiff class excluding youth on runaway and youth in custody less than 30 days.
[2] November and December figures are not yet available.

was used and the following information has been discovered and distributed to the Regional Administrators.

Data entry delay was identified as the greatest reason that EPSDTs were not reflected in the August Monthly EPSDT Report, totaling 109 of the 378 children whose EPSDT screening was not documented. This means that 29.0% of the total undocumented records are due to data entry delay. This is 1.31% of youth in the plaintiff class who have been in custody longer than 30 days (109 of the 8,334 total number of youth who should have had an EPSDT record). The remaining causes that are significant are:

- Lack of Case Management Follow Through (1.13%)
- Contract Agency failing to Schedule EPSDT (.47%)
- Foster Parent failed to schedule EPSDT (.37%)
- Foster Parent re-scheduled EPSDT (.26%)

DCS remains committed to ensuring that all children in custody regardless of their plaintiff class status receive their EPSDT screening and any other needed health care. For the purposes of the John B lawsuit, DCS believes that the following reasons indicate cases where the lack of an EPSDT screening is either outside of DCS control or is not under the purview of the John B. lawsuit.

- Child was sick[3] (.02%)
- Closed adoption case (.05%)
- Released before initial EPSDT (.02%)
- In legal custody only (.08%)
- Not TennCare eligible (.05%)
- Runaway/AWOL[4] (.25%)
- Youth refused, 14 – 17 years old (0%)
- Youth refused, 18 years old or older. (0%)

Beginning June 21, 2003 DCS implemented improvements to DCS TNKIDS system so that all seven components of EPSDT can be tracked. DCS has now collected five months of data, and the format of monthly reports synthesizing this information is in draft form. It will be available by the end of January 2004.

A fundamental way DCS ensures that needed services are provided to a child in custody, is to create a permanency plan for each child, which contains crucial information for those responsible for coordinating the care of the child. The primary purpose of a permanency plan is to provide a "road map" for how the child will achieve permanency, such as reunification with the family, placement with a relative, or adoption. The permanency plans are ratified by the juvenile court, reviewed by foster care review boards made up of judicial appointees, and

[3] Many of the regional health departments clinics do not do sick child visits and the case manager or foster parent did not believe that taking the child to the health department for their EPSDT was in the best interest of the child.

[4] DCS excluded all children whose placement data in TnKids showed that the child was on runaway. These 21 children appear to have been on runaway, but at the time the extract was pulled, the case manager had not updated this information in TnKids.

updated on a set schedule pursuant to statutory requirements. To improve DCS' ability to provide the necessary care, coordination, and follow up, DCS has revised EPSDT policy to clearly direct inclusion of EPSDT results in the permanency plan. In addition, DCS has recently included changes to the permanency plan template to ask the case manager whether the results of the EPSDT screening were included in the plan. In addition, letters from the Department of Health confirming whether all seven components of the EPSDT were completed will be attached to permanency plans. In the last semi-annual report these events were completed, and in the last six months the new template forms have been posted on the DCS web site and the engineering changes incorporating the new permanency plan template have been made in the TnKids system. Training is beginning on the use of this new template and one "train the trainer" session was held on Dec. 9-10, 2003. An additional "train the trainer" session is scheduled for end of February 2004. It is expected that with these improvements, necessary health care treatment will be a more integral part of the permanency planning process and that follow up care will be reviewed by juvenile judges and foster parent review boards.

In order to ensure that case managers complete the necessary follow up care after the EPSDT screening, DCS continues to have DCS Health Unit nurses receive copies of all EPSDT DOH letters that show a need for follow up care. The nurses make sure that the case manager understands the medical information and provides the follow up care necessary.

The Technical Advisory Committee mandated from the Brian A Settlement is in the last steps of giving their approval to protection from harm policies that will guide the department's use of restraint and seclusion as well as the use of psychotropic medications. DCS created workgroups to review and revise these policies, which included: national child welfare and mental health consultants, psychologists, nurses, psychiatrists, representatives of DCS contract providers, representatives of other state agencies, and DCS personnel from several departmental divisions. The workgroups have done an exhaustive review of national standards and best practices, have drafted policies based on this review, and are continuing to finalize those policies. By the terms of the *Brian A* Settlement Agreement, these policies are subject to the approval of the Technical Advisory Committee of said agreement.

DCS is currently working with TDMHDD on developing uniform standards for clinical documentation in DCS contract facilities. Built into these standards is an expectation that DCS contract facilities will document efforts to promote communication among the child's providers and family. In addition, DCS plans on requiring evidence that the facilities begin planning for the child's discharge at the admission of the facility. These guidelines are currently in draft form, and DCS hopes to implement them during the next six months.

Part V: Monitoring and Enforcement of MCO and DCS Compliance Paragraphs 94-103

TennCare
MCO Contract Update:
General Amendment 4 was executed between the MCOs and TennCare to be effective January 1, 2004. This Amendment contains two items for the purpose of strengthening and clarifying EPSDT provisions.

The first change is reflected in Section 2-3.a.1(a) of the Contract, "Physician Benefits" - Additional language was added in order to expand billing an MCO for certain Mental Health diagnosis beyond just PCPs to include certain specialist in order to alleviate some concerns of cost-shifting and service denials (e.g., denial of services for children with autism or other "gap" diagnoses that fall on the boundary between MCO and BHO). The new language in the Physician Benefit Section is as follows:

"CONTRACTOR covered services shall also include medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx)."

The second item amended for EPSDT purposes in this Amendment was clarification regarding an MCO's responsibility to adhere to TennCare Standard Operating Procedures (TSOP). Section 1-2 of the previous/existing TennCare/MCO contract requires MCO compliance with TennCare policies and TSOP 01 defines TSOPs as TennCare policy. However, in order to assure there is no confusion on behalf of an MCO regarding their responsibility to adhere to information provided in a TSOP format, we have clarified the lead in paragraph of Section 4-1 of the Contractor Risk Agreement as follows:

"The CONTRACTOR agrees to comply with all applicable federal and state laws, rules and regulations, policies (including TennCare Standard Operating Procedures (so long as said TennCare Standard Operating Procedure does not constitute a material change to the obligations of the Contractor pursuant to this Agreement), and court orders, including Constitutional provisions regarding due process and equal protection of the laws and including but not limited to:..."

<u>QUARTERLY UP-TO-DATE LIST OF SPECIALISTS</u>

Per Paragraph 62. of the Revised John B. Consent Decree, each MCO is required to provide each primary care provider participating in the EPSDT program an up-to-date list of specialists to whom referrals may be made for screens, laboratory tests, further diagnostic services, and corrective treatment.

During this period, liquidated damages were assessed for EPSDT enrollee cases.

Report of Liquidated Damage Assessed for EPSDT Enrollees
July 1, 2003 to December 31, 2003

BHO/MCO	DIRECTIVE TYPE	DIRECTIVE DESCRIPTION	DEFICIENCY DESCRIPTION	AMOUNT
Premier	LTC	Reimbursement for Service	Late Documentation	$1,600
TBH	LTC	Reimbursement for Service	Late Documentation	$500
MMC/TLC	ORR	Program Issue Violation	Delay in Providing	$925
			Service	
TennCare Select	DFR	Pharmacy	Late Documentation	$500
MMC/TLC	ORR	Program Issue Violation	Notice Requirement	$18,000
			Semi Annual Total	**$21,525**

Mental Health:

TDMHDD/Office of the Medical Director (OMD) utilized the semiannual monitoring process to review randomly selected mental health records of children and youth regarding the mental health services children are prescribed and those services actually received. Data collection on Discharges from the Regional Mental Health Institutes (RMHI's) was completed during the fourth quarter of 2003. This process uses a randomized sample design accepted in the field of mental health research. The data is currently being analyzed and will be available mid January. Analysis includes a review of mental health services prescribed and services received by those children in the sample who were in DCS custody at that time. A review of DCS mental health policies and procedures was begun.

In September 2004, Dr. Freida Hopkins Outlaw, DNCS, RN, CS was appointed as the Children and Youth Director for Mental Health and Developmental Disabilities. Dr. Outlaw received her DNCS from The Catholic University of America in Washington, DC her MSN from Boston College in Chestnut Hill, MA and her BSN, from Berea College in Berea, KY. Dr. Outlaw comes to TDMHDD from the University of Philadelphia,

School of Nursing where she served as Associate Professor of Psychiatric Mental Health Nursing.

Mental Health Contracts:

There were no BHO contract amendments developed by TDMHDD/Office of Managed Care (OMC) during the reporting period of August 1, 2003 through January 31, 2004 that affected enrollees under the age of 21.

Update on Nashville Connection System of Care Grant
Introduction

The Tennessee Department of Mental Health and Mental Retardation received a grant October 1, 1999 from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). The federal program is authorized in Section 561 of the Public Health Service Act and is entitled the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program. The Tennessee grant, entitled the Nashville Connection, is in the amount of $7.25 million federal dollars and $5.9 million state match dollars for a five year period.

Pertinent Findings as of November 2003[1]

Number of children & families[2] *ever served*: 208
Number of children ever served with 2 diagnoses: 40%
Number of children ever served with 3 or more diagnoses: 15%
Number of families ever served participating in the national evaluation 65%
Of 179 children with GAF scores, 163 had a score below 50; 95 had a score of 43 or below.
Enrollment as of 11-13-03: 121
Enrolled children (11-13-03) remaining in the community: 119
Number of schools being served as of 11-13-03: 55
Number of teachers receiving project services 390
Estimated number of students benefiting indirectly from teacher ed 54,000
Overall results of last school satisfaction survey 3.75 out of a possible 4.0 with 4.0 being the best possible score. Next results will be available in January 2004
As measured by the CBCL, child's clinical improvement related to family risk factors (lower number = less problems): see attached report page 5
1 to 3 risk factors: significant drop below clinical threshold from baseline to 12 months.
4 or more family risk factors: experienced steady decline but did not go below the clinical threshold.

Improvement by primary diagnosis between baseline and 6 months (see attached report):

Bi-polar	62% improved	38% no improvement
ADHD	49% improved	51% no improvement
Depression	50% improved	50% no improvement
Conduct Disorder	80% improved	20% no improvement
PTSD	25% improved	75% no improvement

Cost estimates for school based mental health services under the grant (9 months, 180 school days. Total budget: $196,978

Cost per client students	per day: $8.42	per month: $168.36
Cost per school	per day: $20.27	per month: $405.30
Cost per student pop	per day: $0.02	per month $0.41
Cost per teacher	per day: $2.81	per month $56.12

Receiving direct services

Cost estimate for family advocacy and support under the grant (12 months, 177 enrolled youth, does not count other siblings and caregivers, availability is 24/7)

Cost per child	annual: $8,488	per month: $707

Total budget:$1,502,539

Monitoring of the BHOs' delivery of services to children

The Research and Evaluation (R &E) unit of the Office of Managed Care (OMC) regularly monitors the BHOs' service delivery through several mechanisms. On a monthly basis, R & E reviews the BHO case management reports along with TennCare Quality Oversight. Some discussions between R & E and TennCare Quality Oversight have occurred; however, TennCare Quality Oversight continues to lead the monitoring on this standard. Additionally, R & E conducts a quarterly report in regard to the services provided to children in DCS custody who are receiving services through the BHO. The most recent report was completed in November 2003. The R & E unit also reviews the BHOs' quarterly quality improvement reports, which contains data on their progress with contractual performance standards. The contractual performance standards reviewed by R & E in regard to children include provider network (geo-access standards), outpatient appointment timeliness, case management, ambulatory follow-up after discharge from inpatient or residential treatment, and inpatient readmission rates. Each quarter OMC staff meets with the BHO staff to discuss any issues regarding their compliance with these standards and work with the BHO to improve any areas of deficiency. In December 2003, R & E completed a review of the BHOs' 3rd quarter quality improvement report.

Monitoring Access to Services:

The Department of Mental Health and Developmental Disabilities (TDMHDD) in conjunction with AdvoCare of Tennessee, the Behavioral Health Organization (BHO) has reviewed/implemented proposals from providers state-wide for the purpose of expanding and enhancing children 's services. Approval/denial letters were sent to providers in December 2003. Expansion of services includes grants as follows:

6 telemedicine grants to include equipment and line usage for the primary objective of medication management for under served geographic areas of the state
9 grants for additional child psychiatrist/nurse practitioner time
4 grants for school based services
3 grants for MH services at primary care giver's office
2 grants for dual MH/A&D services
1 grant for A&D only services
1 grant for specialized OP (specific to physically/sexually abused children)
1 grant for girls group therapy
2 grants for added days of after hours intakes
1 grant for a bilingual service

There were no BHO contract amendments developed by TDMHDD/Office of Managed Care (OMC) during the reporting period of August 1, 2003 through January 31, 2004 that effected enrollees under the age of 21.

TennCare Appeals

One way to identify and track problems in service delivery is through the appeals process. When EPSDT enrollees or persons acting on their behalf file appeals, there is a lot we can learn about where there are problems with provider availability, where there is confusion about the program, and so forth.

TennCare Office of General Counsel

The Office of General Counsel (OGC) at TennCare is responsible for preparing medical service appeals for hearings before an Administrative Law Judge and litigating these appeals on behalf of the Bureau of TennCare. OGC also works in an advisory capacity with the TennCare Solutions Unit (TSU) and the TennCare Office of Contract Development and Compliance (OCDC). A large part of this collaboration is directed towards improving compliance with the requirements for EPSDT, the *Grier* Revised Consent and the *Grier* Revised Consent Decree (Modified).

During the July to December period, OGC received a total of 598 EPSDT appeals. Of the 598 total appeals, 363 were appeals for dental services, 83 pharmacy, 56 BHO appeals, and 96 were medical appeals. During the same

period, OGC resolved 648 appeals, 324 (50 %) of these were dental/orthodontic EPSDT cases.

During this time, OGC intensified its focus on notice requirements pursuant to the federal fair hearing regulations and the *Grier* Revised Consent Decrees. In the process, OGC devoted a considerable amount of time and assistance to helping the MCC's improve notice to enrollees of denials of EPSD&T services. The major problems observed in the past months have been in the area of dental and orthodontic services for EPSDT enrollees.

OGC identified several compliance problems with the MCC denial letters for these dental services to enrollees under 21 years of age. During the period under review, OGC devoted a significant amount of time and direct technical assistance to the MCC with the objective of eliminating these compliance problems and giving appropriate notice to enrollees of the reason for the denial of the service. There has been a significant improvement in this respect, and OGC continues to work in this area to further improve compliance.

TennCare Solutions Unit

The TennCare Solutions Unit (TSU) is the medical appeal resolution unit for TennCare. During the six months covered by this report, the unit has continued to undergo quality improvements intended to create better efficiencies, produce more informative data and better support the unit in its medical decisions regarding appeals. TSU works closely with Schaller-Anderson of Tennessee, Inc. (SAT), the contractor responsible for performing all appeal related medical necessity evaluations and with internal units such as the Office of General Counsel and the Office of Contract Development and Compliance in carrying out its activities.

By far, the greatest change during this period resulted from the decision to carve-out all medical pharmacy services from the Managed Care Organizations. During the second half of 2003, the Bureau of TennCare developed and implemented a Preferred Drug List (PDL). The pharmacy changes reduced the overall numbers of EPSDT appeals from an average of over 2,000 per month to 1,000 per month.

The following issues are the major EPSDT issues identified by the TSU during this six-month period.

Xantus Health Plan & MCO change requests: On August 1, 2003, Xantus Health Plan ceased serving TennCare enrollees throughout middle Tennessee. The TSU received a high number of requests for MCO change prior to the plan' s closing and worked to ensure that enrollees received all medically necessary covered services throughout the transition to their new plan. In addition the unit has experienced a higher than normal number of requests for MCO change from enrollees in rural West Tennessee. The latter is due to network differences and the desire of enrollees to choose their physician.

TennCare Pharmacy Carve-Out: The TSU redesigned its pharmacy process during 3rd quarter 2003 to ensure a smooth transition from the MCO to TennCare of the pharmacy appeals resolution process. As of July 1, 2003 the MCOs are not contracted to perform pharmacy services and thus are not involved in resolving appeals for pharmacy services. This required the TSU to perform the research and resolution functions previously performed by the MCO as per the Grier Consent Decree. Pharmacy appeals during the 2nd half of 2003 experienced a dramatic decrease and are no longer the most appealed for EPSD&T service. Appeals are primarily received for non-covered medications. During the six-month period the total number of pharmacy appeals received dropped from 6,764 to 409.

Dental: The TSU continues to work closely with Doral Dental and the TennCare Dental Director to coordinate the resolution of all appeals. During the six months covered by this report, the predominant issues for dental appeals continue to be for orthodontia and for delays in service for children in state custody, the latter filed by advocates acting in behalf of the child.

Better coordination for children in state custody: The TSU continues to strive to increase communication and strengthen the relationship between the TSU and the advocacy group for children in state custody. The advocates and the TSU conduct a weekly paper review of new appeals to ensure that all are being reviewed timely and completely. Additionally, the TSU now meets monthly (in-person) with the children's advocacy group to discuss difficult cases and coordination functions. Appeals are filed predominantly by the advocates and case managers.

Expedited vs. Non-Expedited Appeals: Virtually all appeals, with the exception of pharmacy, are now being filed as expedited appeals. This trend has continued to increase over the last year.

Summary of reports

The Schaller-Anderson reports attached provide data on EPSDT related appeals activity during the second six months of 2003 and are specific to type of appeal, appeal totals per plan and in the aggregate. **(See Attachment B)**. These reports are categorized as follows:

1. **Overall EPSDT Appeals by Month**
   Details the number of appeals in the aggregate for each of the 6 months. The number of appeals has continued to decrease during the six-month period and can be primarily attributed to the changes in the pharmacy program.

2. **EPSDT Area of Appeals**
   Details the types of appeals by volume. Pharmacy no longer represents the largest type of appeal as is also true for adults. In the first half of 2003, pharmacy appeals alone accounted for 53% of all EPSDT appeals. During this reporting period, pharmacy appeals represented only 6.7% of appeals. MCO Change Appeals are now the largest are of appeal followed

by reimbursement and billing appeals. MCC Change and Reimbursement and Billing appeals represent 65.9% of all appeals received. DCS appeals decreased from 424 to 340 (5.6% of all appeals), while BHO appeals decreased slightly from 170 to 164 appeals

3. EPSDT Appeals Resolution by Level

Details the numbers of appeals resolved at each level of the appeals Process during the six-month period. As this report includes appeals filed in the previous period which are resolved in this period, and excludes appeals filed in this quarter that are still pending, the number of appeals resolved does not match the number received during the reporting period. Ninety percent of all appeals resolved during this reporting period were resolved in the TSU either by the MCC reversing its decision or by action taken by the TSU. Only ten percent of all appeals received required transfer to the Office of General Counsel for an Administrative Law Judge hearing.

4. EPSDT Appeals per K TennCare Enrollees by MCO by Month

Details the number of appeals by MCO plans per 1,000 enrollees for each of the six months. This report only includes the MCOs that are still active participants in TennCare.

5. EPSDT Enrollment Percentages by MCO and Region

Details the number of appeals by MCO and region of the state. TennCare Select, the only state-wide plan, received 36% of all appeals during the reporting period.

6. EPSDT Comparative Appeal Timelines

Details the percentage of expedited vs. non-expedited appeals received during the reporting period. Approximately 53% of all appeals received are expedited. However, when pharmacy appeals are removed from this equation, the data shows that virtually all non-pharmacy appeals are now received as expedited appeals (31 day resolution process as opposed to 90 day process).

7. EPSDT Appeals per K by Month by Regions

Details the numbers of appeals received by region. During the reporting period there was an increase in the number of EPSDT appeals received in the Northwest and Southwest regions. This was predominantly caused by requests for MCO changes.